IV. Cultural Competency

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How to Use This Section

In this section you will find guidance to support developing a culturally competent system. Each section contains summarized guidance and tools to assist you. If you are in the very beginning stages of assessing for cultural competency within your system, it is recommended that you review the sections from the beginning. If you are further along, then it is recommended that you review each question and review materials under the one that best supports the current stage of development.

Under most questions you will also find useful "**TOOLS**" to assist you in that particular area of cultural competency development. Each of these tools will have a link with the title as well as a brief summary of its use. The **TOOLS** section may also include other helpful links, websites or articles.

Why is Cultural Competency Important and What Is It Anyway?

System of care, the Surgeon General's Report on Mental Health and the supplement on culture, race, and ethnicity (http://www.surgeongeneral.gov/library/mentalhealth/cre/), the National Agenda for Achieving Better Results for Children and Youth with Serious Emotional Disturbance (Office of Special Education Programs, 1994), and the President's New Freedom Commission as well as best practices have all stressed the importance of addressing cultural issues in serving children with mental health, substance abuse, and emotional challenges and their families.

Why is it important? Culture influences many aspects of mental health challenges, substance abuse, and developmental disabilities. Culture affects among other factors:

- how children and families talk about their strengths and needs
- what is defined as "abnormal"
- how symptoms show up
- ways of coping
- family and community supports
- comfort in seeking treatment
- treatment effectiveness

Similarly, the culture of the service systems and service providers influence diagnosis, treatment, and service delivery. A culturally competent system of care acknowledges and incorporates--at

all levels--the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge and the adaptation of services to meet culturally unique needs (Cross et al., 1989).

The degree to which services are culturally competent influence the degree to which families may even access services (e.g., when and how a service is provided, the time the service is offered, availability of providers who are bilingual) and the likelihood that an intervention will be successful.

In the growing emphasis on evidenced-based practice, cultural competence really defines "practice-based evidence." That is, how do you adapt an evidenced-based practice for this particular child and family, in this particular setting, for this particular challenge.

In order for systems to accomplish cultural competency, they must first clearly define what is meant by culture and the various terms associated with cultural competency (e.g., cultural sensitivity, linguistic competence). Next, they must assess the current status of cultural proficiency, take steps to build competency and continuously monitor, evaluate and plan toward cultural competency.

Definitions

What is Culture?
Cultural competence is defined as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross–cultural situations (Cross et al., 1989; Isaacs & Benjamin, 1991). Operationally defined, cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services; thereby producing better outcomes (Davis, 1997). Culture is the conventional patterns of thought, activity, and artifact that are passed on from generation to generation (Brown, 1991). Thus, while race and ethnicity are part of one's culture, culture is broader than race and ethnicity. It includes one's values and beliefs, customs and can be influenced by a number of factors such as where you grew up (rural/urban), religious beliefs or lack thereof, size of family, martial status, role of extended family, language spoken, etc.

What is Cultural Sensitivity?
A person's capacity to respond psychologically to cultural changes in his/her interpersonal or social relationships.

What is Cultural Competency?

Key aspects of cultural competency are skills, understanding, appreciation, willingness, and ability. Because of its complexity, cultural competency is challenging to achieve, especially with the increasing diversity of our communities. Many say it is a "journey not a destination" involving:

- a set of academic and interpersonal skills that increase ones understanding and appreciation of cultural differences and similarities within, among, and between groups (Orlandi, 1992) and
- a willingness and ability to draw on community-based values, traditions, and customs and to work with knowledgeable persons of and from the community in developing focused interventions, communications, and other supports (Orlandi, 1992)

There is a large body of literature about ways to think about cultural competence. Most discuss some sort of stages through which individuals as well as systems pass through. The U.S. Health Service Research Administration (HRSA) has highlighted five of these conceptualizations (see http://www.hrsa.gov/culturalcompetence/measures/sectionii.htm; see handout on summary of conceptualizing cultural competence).

Perhaps the most frequently cited is the work by Cross and colleagues (Cross, T.L., Bazron, B.J., Dennis, K.W., Isaac, M.R., and Campinha-Bacote, J.). Cross et al. define cultural competence as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations."

They view cultural competence as a process or continuum whereby an individual's view of other cultures transforms from destructive or unaware to proficient.[3] There are six possible points along this continuum:

1. Cultural destructiveness,
2. Cultural incapacity,
3. Cultural blindness,
4. Cultural pre-competence,
5. Cultural competence, and
6. Cultural proficiency.

They also describe several conditions that must exist in order for professionals to move along this continuum. Professionals must:

- value diversity
- understand their cultural biases
- be conscious of the dynamics that occur when cultures interact
- internalize cultural knowledge, and
- develop adaptations to diversity

Similar to Cross, et al., Campinha-Bacote views cultural competence as a process, not an endpoint, in which providers see themselves as *becoming* culturally competent rather than *being* culturally competent. They do not identify points in this process but do identify five essential components of competence that include:

1. Cultural awareness,
2. Cultural knowledge,
3. Cultural skill,
4. Cultural encounters, and
5. Cultural desire.

Other approaches such as those by Carballeira, Leininger, and Davidhizar and Giger focus more on the methods a professional might use in order to become culturally competent and provide culturally competent care. In these approaches, cultural competence is a goal that can be reached when a skill set is learned with the proper training.

Carballeira identifies that the key is a cross-cultural exchange of attitudes between the providers and the child/family. The provider's cultural attitude falls within a range: superiority, incapacity, universality, and sensitivity, to competence. The author suggests the use of the "LIVE & LEARN" model. In this model, the acronym "LIVE" stands for Like, Inquire, Visit, and Experience, while "LEARN" stands for Listen, Evaluate, Acknowledge, Recommend, and Negotiate. The key skills are that the provider respects client beliefs and values, avoids stereotyping, and strives to develop with the child and family mutually acceptable objectives and measures for changed behavior in a treatment plan.

Leininger's "Sunrise Model" focuses on the steps a provider should take in order to learn from the child and family information key to developing a culturally competent treatment plan. Leininger believes that the Western medical model fails to explore cultural patterns of illness. The Sunrise Model suggests that the world view and social structure of the client are important areas to investigate and can be explored using seven dimensions:

1. Cultural values and lifeways,
2. Religious, philosophical, and spiritual beliefs,
3. Economic factors,
4. Educational factors,
5. Technological factors,
6. Kinship and social ties, and
7. Political and legal factors.

Professionals must develop the skills, knowledge, and patience to explore and validate what the patient says and does. Once information is obtained for each of the dimensions, the goals and objectives and methods for treatment can be jointly crafted.

Similarly, Davidhizar and Giger present a transcultural assessment model to assist professionals in working with clients from diverse cultures that focuses on six factors:

1. Communication,
2. Space,
3. Time,
4. Social organization,
5. Environmental control, and
6. Biological variations.

The various approaches to conceptualizing cultural competence stress the importance of viewing cultural competence as a dynamic process involving continual progression and involvement of all levels…both personally and systemically.

What is Linguistic Competence?
Linguistic competence is the capacity of an organization and its personnel to communicate effectively and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities.

What Do We Do Next?
So once we understand why cultural competency is important and we understand the many definitions of culture, how do we become culturally competent? According to the National Center for Cultural Competence at Georgetown University http://www11.georgetown.edu/research/gucchd/nccc/foundations/frameworks.html, cultural competence requires that organizations:

- have a defined set of values and principles, and demonstrate behaviors, attitudes, policies and structures that enable them to work effectively cross-culturally;
- have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge and (5) adapt to diversity and the cultural contexts of the communities they serve; and
- incorporate the above in all aspects of policy making, administration, practice, service delivery and involve systematically consumers, key stakeholders and communities.

Cultural competence is a developmental process that evolves over an extended period. Both individuals and organizations are at various levels of awareness, knowledge and skills along the cultural competence continuum (adapted from Cross et al., 1989).

How Do We Assess for Our Current Level of Cultural Competency?

So how do we get there? An individual and a system must know where they are beginning, but then they must know where they are going and how to recognize it when they get there. Self-assessments can lead to a greater awareness of cultural opinions when employees are asked to assess their own awareness.

Several potential changes can begin simply by requiring system-wide assessments:

1) the questions alone may prompt people to think about how they view certain issues or situations;
2) the assessment questions may help people think through what their system's current status is and where they may need to begin making changes and adjustments; and
3) the assessment may help people become more conscious of personal and professional norms and how that may affect decisions, especially if they are holding leadership or policy making positions.

TOOLS

> ***Promoting Cultural Diversity and Cultural Competency*** *(National Center for Cultural Competence Georgetown University Child Development Center University Center for Excellence in Developmental Disabilities):* This checklist is intended to heighten the awareness and sensitivity of personnel to the importance of cultural diversity and cultural competency in human service settings.

System or organizational assessments assist the agency in:

- Gauging the degree of which they are effectively addressing the needs and preferences of culturally and linguistically diverse groups,
- Establishing partnerships that will meaningfully involve families/consumers and key community stakeholders,
- Improving family/consumer access to and utilization of services and enabling supports,
- Increasing family/consumer satisfaction with services received,
- Strategically planning for the systemic incorporation of culturally and linguistically competent policies, structures and practices,
- Allocating personnel and fiscal resources to enhance the delivery of services and enabling supports that are culturally and linguistically competent, and
- Determining individual and collective strengths and areas for growth.

TOOLS

> ***A Guide to Planning and Implementing Cultural Competence Organizational Self Assessment*** *(National Center for Cultural Competence Georgetown University Child Development Center University Center for Excellence in Developmental Disabilities):* This document illustrates the process and purpose for organizational self assessments.

Planning for Cultural and Linguistic Systems of Care *(National Center for Cultural Competence Georgetown University Child Development Center University Center for Excellence in Developmental Disabilities):* This checklist was developed by the national Center for Cultural Competency and is one in a series designed to assist organizations and systems of care to develop policies, structures and practices that support cultural and linguistic competence.

Cultural Competence Continuum: This chart reflects the stages of Cultural Competence. It can be used to assess for where your system or individuals are with attitudes, services, activities, materials, etc.

Conceptualizations of Cultural Competence: This chart summarizes the different ways in which the field has conceptualized cultural competence.

Kaleidoscope: This information was compiled from interviews with people living in the Guilford County community who have come from another country. It reflects their personal insights into their cultural heritage and traditions. This resource is meant to be used not as "an end all to be all" source of information about particular cultural groups, but rather as a reference guide…an introduction to each group's culture…an overview of cultural practices generally considered to be common to people from a particular geographic location outside this country. The hope is that this resource guide will facilitate a two-way communication between the service provider, teacher or counselor and the consumer of services or student. It is meant to provoke questions, not make assumptions or reflect stereotypes and that it will assist in providing a means for our community to become more culturally competent. (see www.uncg.edu/csr and CD).

How Do We Create a Culturally Competent System?

After self and/or program assessment, decisions must be made on where and how to proceed in order for service providers and systems to increase their ability to deliver culturally competent services. Three things are essential.

(1) There must be both individual commitment and system/agency commitment in order to see real change.
(2) Markers or indicators of cultural competence must be clearly identified. Some of the concepts of cultural competence can be abstract and without clear operationalization of terms, it is difficult to assess current status or identify steps to change. It helps to begin to identify, with consumers, how cultural competency would look in all areas…in treatment, in research, in training, and in supervision.
(3) There must be a commitment to ongoing evaluation, monitoring, and review of progress.

A review of the literature and guidance materials developed from a number of organizations (e.g., Center for Cultural Competence at Georgetown University, U.S. Health Resources and Services Administration), yield nine key areas that should be targeted:

1. Values and attitudes,
2. Cultural sensitivity,
3. Communication,
4. Policies and procedures,
5. Training and staff development,
6. Facility characteristics, capacity, and infrastructure,
7. Intervention and treatment model features,
8. Family and community participation, and
9. Monitoring, evaluation and research.

Domain 1: Values and attitudes

Values and attitudes refer to the set of beliefs and mindsets possessed by providers, administrative staff, health care organizations and others involved in service delivery. In order to address this area, training and assessment must emphasize cross-cultural interactions in order for providers to increase the awareness of the values and attitudes they bring to the consumer-provider interaction as well as the values and beliefs that consumers have with regard to health, medical treatment, and authority. This can be accomplished through active listening, open-ended questions, and a nonjudgmental attitude toward the differences that are encountered.

Domain 2: Cultural sensitivity

While values and attitudes refer to the beliefs held by health care professionals, cultural sensitivity refers to heightened knowledge of the needs of the client and is often evidenced by a provider's ability to accurately interpret and respond to non-verbal or other cultural cues or in the way in which health care organizations provide information to their clients. This is a necessary but not necessarily sufficient condition to move forward on the journey toward cultural competence. For example, it is possible for a provider or agency to be culturally aware but still not change behaviors to become culturally competent. That is why it is critical to develop a personal or agency plan that specifically targets behaviors to be changed, with clear indicators and a timeline in order for culturally competency to improve.

Domain 3: Communication

Communication encompasses a wide range of activities, both oral and written, that describe the flow and exchange of information among those involved in the provision and receipt of care, including interpersonal exchanges and exchanges between individuals and organizations (from: http://www.hrsa.gov/culturalcompetence/measures/sectionii.htm). Cultural competence involves a number of factors including: increasing the availability and accessibility of language services (e.g., interpretation and translation) but also understanding different communication styles including the multiple meanings of words and of nonverbals.

Domain 4: Policies and procedures

Policies and procedures are the key programmatic and planning tools through which organizations can facilitate the provision of culturally competent care. These include:

- Presence and effectiveness of conflict resolution processes
- Hiring procedures including degree to which cultural competence indicators are written into job descriptions and incorporated into hiring decisions
- Breadth of provider networks
- Degree to which provider networks match consumers
- Incentive systems such as degree to which cultural competence indicators are integrated into promotion, salary recommendations

As an agency or professional moves toward cultural competence, they begin to understand the interplay between policy and practice and are committed to policies that enhance services to diverse clientele. Those that are culturally blind (a mid-point along the continuum) may believe that they are implementing culturally competent policies when, in fact, their policies may be discriminatory and ultimately restrict access to services. When an agency or professional reaches cultural proficiency, policies are flexible and culturally impartial. Partnering with consumers that reflect the diversity of those served, is critical in being able to develop policies and procedures that support the agency's journey toward cultural competence.

Domain 5: Training and staff development

Training and staff development is key in providing professionals the knowledge and skills required for culturally competent care. Conducting a culturally competent assessment that identifies the providers' individual skill and knowledge level represents a starting point from which to develop programs and curricula to develop cultural competence. This includes not only training that happens in the inservice and continuing education level but also the training that happens in academic institutions.

One approach that reflects the concept of cultural competence being a journey is what is referred to as the conscious competence learning model. The model explains the process and stages of learning a new skill (or behavior, ability, technique, etc.) and provides a useful framework for training (see also section of toolbox on training). The general progression is from stage 1 - 'unconscious incompetence', and ends at stage 4 - 'unconscious competence', having passed through stage 2 - 'conscious incompetence' and - 3 'conscious competence' (see handout on Cultural Competence Continuum and Conscious Competence Matrix).

Teachers and trainers commonly assume trainees to be at stage 2, and focus effort towards achieving stage 3, when often trainees are still at stage 1. The trainer assumes the trainee is aware of the skill existence, nature, relevance, deficiency, and benefit offered from the acquisition of the new skill. Whereas trainees at stage 1 - unconscious incompetence - have none of these things in place, and will not be able to address achieving conscious competence until they have become consciously and fully aware of their own incompetence. *This is a fundamental reason for the failure of a lot of training and teaching and is particularly true of training within system of care.*

If the awareness of skill and deficiency is low or non-existent (i.e., the learner is at the unconscious incompetence stage), the trainee or learner will simply not see the need for learning. It is essential to establish **awareness** of a training need (conscious incompetence) and the

benefits for achieving that skill prior to attempting to impart or arrange training or skills necessary to move trainees from stage 2 to 3.

The progression is from quadrant 1 through 2 and 3 to 4. It is not possible to jump stages. For some skills, especially advanced ones, people can regress to previous stages, particularly from 4 to 3, or from 3 to 2, if they fail to practice and exercise their new skills. A person regressing from 4, back through 3, to 2, will need to develop again through 3 to achieve stage 4 - unconscious competence again. For certain skills in certain roles, particularly with cultural competence, stage 3 conscious competence is quite good. As with anything, some skills are easier for some individuals to learn than for others.

Domain 6: Facility characteristics, capacity, and infrastructure

Facility characteristics, capacity, and infrastructure refer to issues related to the access and availability of care and the environment in which it is provided, including location, hours of operation, physical resources, and information systems. Often, these issues influence consumers' experiences in a health care delivery setting and can hamper their capacity or even willingness to access it. An organization seeking to become culturally competent can address the needs of different cultures by developing service models that are adapted to the cultural-specific needs of the population (e.g., the process of combining evidenced-based practice with practice-based evidence). Again, partnering with consumers, especially through formal structures such as governing board or advisory council is an excellent way to gain input that can guide these programmatic decisions. Another is looking at data on utilization to determine what types of services and manner of provision seem to be utilized more or less frequently.

Domain 7: Intervention and treatment model features

Interventions and treatment model features focus on aspects of evaluation, diagnosis, treatment, and referral services. These can include how traditional healing beliefs interrelate with the Western medical model, ethnopharmacology, inclusive decision-making, care coordination, and, in a managed care context, health benefit design. Conducting culturally competent evaluations are key including choosing assessment tools that have been developed with consumers that match those being served (e.g., standardization sample, research on applicability with certain groups) as well as asking key questions about values and attitudes (see Domain 1). For example, the Diagnostic and Statistical Manual (4th Edition; DSM IV) includes an Appendix that provides guidelines for conducting a cultural formulation. Basing diagnoses on a cultural assessment that is sensitive to the cultural needs and beliefs of the child and family and sharing it with consumers in a culturally sensitive manner can contribute to consumers' increased understanding of diagnoses and treatment and can lead to a workable treatment plan.

Domain 8: Family and community participation

Family and community participation refers to family-centered care that recognizes the important role of the family and the larger community in the provision of health care. Community participation in assessments and community outreach efforts provides valuable information in order to increase providers' understanding of consumers' cultural backgrounds and support

structures and to include these perspectives into policy planning and development and other activities.

Domain 9: Monitoring, evaluation and research

A key part of developing cultural competence is setting goals and timelines and monitoring and evaluating current efforts in order to assess the extent to which cultural competence is present, is maintained, and contributes to desired results with respect to care. This includes assessing the demographics of the children and families served (e.g., ages, where they live, economic conditions, race/ethnicity) and the degree to which the consumers served and the providers hired match those demographics. It also means being aware of the degree to which certain mental health and health challenges may occur more frequently within these different demographics. How do you know cultural competence when you see it? You need to develop a quality improvement plan that identifies indicators in the organization's structures, processes, outcomes, and viewpoints.

- **Capacity/structure measures**: assess the organization's capability to support cultural competence through adequate and appropriate settings, infrastructure, including staffing, facilities and equipment, financial resources, information systems, governance and administrative structures, and, other features related to organizational context in which services are provided.
- **Process measures:** assess the content and quality of activities, procedures, methods and interventions in the practice of culturally competent care and in support of such care.
- **Impact/outcome measures:** assess the contribution of cultural competence to the achievement of various levels of objectives (e.g., intermediate, ultimate), with respect to the provision of care, the response to care, and the results of care.
- **Organizational viewpoint measures:** assess the values, principles, perspectives, outlook, and organizational attitudes espoused and displayed by an organization as these relate to cultural competence.

  (Adapted from: http://www.hrsa.gov/culturalcompetence/measures/sectioniii.htm).

One of the tools attached is an extensive summary of examples of indicators in these domains along with references (see Indicators of Cultural Competence). Adapted from the cultural competence materials from HRSA, this table provides specific questions that can be developed into a comprehensive assessment and targeted plan in each or all of the domains.

In summary, in order to move along the continuum of cultural competency, individuals and/or organizations must:

- Develop a written strategic plan to address disparities.
- Know and understand the various cultural groups present in the community served.
- Recruit and retain a diverse staff that is representative of the community.
- Plan to include readily accessible bilingual/bicultural staff or translators
- Provide language assistance at all points of contact as needed.
- Provide translated vital service documents, program documents, and rights and grievance information.

- Provide ongoing training about the cultural groups served and assure strategies employed are effective across cultures.
- Include assessment of cross-cultural interactions as part of the employee evaluation and supervisory processes.
- Consider various methods and media for mental health information exchange and education and promotion.
- Adapt service environments, practices and delivery to match the individuals and families served.
- Collect demographic data about the community at large and service recipients to determine future directions for program development.
- Develop partnerships with community leaders, cultural brokers and natural networks to facilitate increased service access and to provide feedback that will guide service design.
- Examine agency and individual outcomes to determine whether specific groups within the service population are over or under represented, to track consumer satisfaction, and to promote consumer driven services (4)

TOOLS

Engaging Communities to Realize the Vision of One Hundred Percent Access and Zero Health Disparities: A Culturally Competent Approach
Health care organizations should give careful consideration to the values and principles that govern their participation in community engagement. This checklist is designed to guide them in developing and administering policy that supports cultural and linguistic competence in community engagement.

Planning, Implementing and Evaluating Cultural and Linguistic Competency for Comprehensive Community Mental Health Services for Children and Families:
This checklist was developed by the National Center for Cultural Competence (NCCC). It is one in a series designed to assist organizations and systems of care to develop policies, structures and practices that support cultural and linguistic competence. This checklist focuses on systems of care and organizations concerned with the delivery of services and supports to children and youth with emotional, behavioral and mental disorders and their families. Cultural competence is a key principle that must be integrated within all aspects of systems of care. This checklist is also designed to support efforts by the Child, Adolescent and Family Branch, Substance Abuse and Mental Health Services Administration, U.S. Department of Health & Human Services to eliminate racial and ethnic disparities in mental health.

Cultural Competence Continuum: This chart reflects the stages of Cultural Competence. It can be used to assess for where your system or individuals are with attitudes, services, activities, materials, etc.

Conscious Competence Matrix: This document includes the matrix referred to in the above Training and Staff Development portion of Section IV.

Helpful Links and Articles

Websites:

Resource List: Diversity Resources

Creating Cultural Competence Organizations and agencies

http://gucchd.georgetown.edu/nccc/index.html

http://www11.georgetown.edu/research/gucchd/nccc/

http://www.med.umich.edu/multicultural/ccp/basic.htm#gen.

Cultural Brokers

http://gucchd.georgetown.edu/nccc/documents/Cultural_Broker_Guide_English.pdf

Cultural Competence Standards in Mental Health

http://www.wiche.edu/MentalHealth/Cultural_Comp/ccslist.htm#4groups

Culturally Specific Standards in Mental Health

http://www.wiche.edu/MentalHealth/Cultural_Comp/ccsaftoc.htm

http://www.wiche.edu/MentalHealth/Cultural_Comp/ccsasiantoc.htm

http://www.wiche.edu/MentalHealth/Cultural_Comp/ccslattoc.htm

http://www.wiche.edu/MentalHealth/Cultural_Comp/ccsnatoc.htm

Tools and processes for Self-assessments

http://gucchd.georgetown.edu/nccc/selfassessment.html

http://gucchd.georgetown.edu/nccc/documents/ncccorgselfassess.pdf

http://gucchd.georgetown.edu/nccc/documents/Checklist.CSHN.doc.pdf

http://gucchd.georgetown.edu/nccc/documents/selfassessment.pdf

http://www.med.umich.edu/multicultural/ccp/assess.htm.

Products and Tools to Assess Cultural Competence Values and Principles in Organizations

http://gucchd.georgetown.edu/nccc/products.html

Engaging Diverse Communities

http://gucchd.georgetown.edu/nccc/documents/ncccpolicy4.pdf

Planning and Evaluating Cultural Competence

http://gucchd.georgetown.edu/nccc/documents/Getting_Started_SAMHSA.pdf

Rational for Cultural Competence

http://gucchd.georgetown.edu/nccc/cultural5.html

Building Relationships across cultural lines

http://www.med.umich.edu/multicultural/ccp/approaches.htm#tips

Videos

Blue-Eyed, a video demonstrating the effects of stereotyping others, by California Newsreel, see www.newreel.org

Centers of Excellence in Culturally Competent Care (2003). Kaiser Permanente. To order, contact the Kaiser Permanente National Diversity Hotline at (510) 271-6663.

Cultural Issues in the Clinical Setting. Teaching video vignettes with facilitator's guide, 2003, 2004. Kaiser Permanente Multimedia Productions and The California Endowment. To order, contact: Gus Garona, Kaiser Permanente National Media Communications, Media Distribution, at (323) 259-4776.

The Culture of Emotions. A Cultural Competency and Diversity Training Program. Mental Health. To order, contact: Harriet Koskoff at (415) 864-0927.

Race: The Power of an Illusion, a video by California Newsreel, see www.newsreel.org Companion Website sponsored by PBS at http://www.pbs.org/race/000_General/000_00-Home.htm

Worlds Apart: A Four-Part Series on Cross-Cultural Healthcare (2003), by Maren Grainger-Monsen, M.D., and Julia Haslett, Stanford

References and Key Articles

Abt Associates (2000). *Report on recommendations for measures of cultural competence for the quality improvement system for managed care.* Prepared for the Health Care and Financing Administration. Washington, DC.

This report includes a set of recommendations for measures of cultural competence of managed care organizations that provide care to Medicare and Medicaid beneficiaries under contracts with HCFA or with State Medicaid agencies. The measures were developed for use in the Quality Improvement System for Managed Care (QISMC), which is a system designed to ensure that organizations providing health care services under contract protect and improve the health and satisfaction of enrolled beneficiaries. Recommendations for measures were developed from input from experts in the field of cultural competence. The Expert Panel recommended that HCFA develop measures of the following three types: 1) disparity-based measures; 2) enrollee-based measures; and 3) standards-based inventories of current practices. Disparity-based measures would identify disparities in access to care and disparity in preventive care, such as flu shots. Enrollee-based measures would assess the beneficiaries' ability to choose congruent providers and language services. Standard-based measures would assess whether MCO had a process for identifying and addressing disparities.

Campinha-Bacote, J. (1994). *The process of cultural competence in health care: A culturally competent model of care***.** Perfect Printing Press. Wyoming, OH.

Campinha-Bacote presents a culturally competent model of care with four components on a continuum: (1) cultural awareness, (2) cultural knowledge, (3) cultural skill and (4) cultural encounters. Cultural awareness is defined as having cultural sensitivity and avoiding cultural biases. Cultural knowledge is defined as the care provider understanding the cultural would view and theoretical/conceptual framework of the patient. Cultural skill is defined as the provider having developed the skill-set to access an individual's background and formulate a treatment plan that is culturally relevant. Cultural encounters are the processes which allow the health care provider to directly engage in cultural interaction with clients from culturally diverse backgrounds. Additionally the article provides a checklist of the "Six A's for Culturally Responsive Services" as a as keys to providing access of services to underserved and culturally/ ethnically diverse populations. The six A's are: (1) available, (2) accessible, (3) affordable, (4) acceptable, (5) appropriate, and (6) adoptable.

Campinha-Bacote, J. (1999). A model and instrument for addressing cultural competence in health care. *Journal of Nursing Education, 38*(5), 203-207.

This article presents the author's Inventory to Assess the Process of Cultural Competence (IAPCC) among healthcare professionals, an instrument that measures the constructs of cultural awareness, cultural knowledge, cultural skill, and cultural encounters among health care professionals. The IAPCC is a self-administered survey that uses a 4-point Likert scale to score 20 different items. These 20 items address each of the four constructs. The full instrument is not included.

Carballeira, N. (1997). The LIVE and LEARN model for cultural competent family services. *Continuum, 17*(1), 7-12.

The author applies a model of cross-cultural attitudes to shed light on what happens whenever a provider and a client from different cultures meet. The author suggests that whenever the provider manifests a cultural attitude, the client exhibits some reaction. The model of cross-cultural attitudes and client reactions fall in a range from superiority – incapacity – universality – sensitivity – to competence, whereas the client reactions range from resistance – accommodation – to adaptation. The author proposes the LIVE & LEARN model which stands for: Like- Inquire – Visit – Experience and Listen – Evaluate – Acknowledge – Recommend – Negotiate. The model presents providers with a practical, phased approach to cross cultural service delivery that respects client centrality, avoids stereotyping, and leads to the adoption of mutually acceptable objectives and measures for changed behavior.

Center for Mental Health Services (1998). *Cultural competence standards in managed mental health care: Four underserved/underrepresented racial/ethnic groups***.** Prepared for the Substance Abuse and Mental Health Services Administration, Department of Health and Human Services. Purchase Order No. 97M047622401D.

This report addresses the need to ensure the provision of culturally competent services to underserved and underrepresented racial/ethnic groups in managed care settings. The report provides tools to guide the provision of culturally competent mental health services to four racial/ethnic populations: Hispanics, American Indians/Alaska Natives, African Americans and Asian/Pacific Islanders. Input was gathered from expert panels of consumers, mental health services providers and academic clinicians representing each of the four racial/ethnic populations. Each panel reviewed mental health research and services literature that focused on their respective population and developed a consensus around how best to achieve culturally competent managed behavioral health care for its target population. Two types of standards were developed: overall system guidelines, and clinical standards and implementation guidelines. Overall system guidelines focused on ensuring a culturally competent system of care and included standards on cultural competence planning, governance, benefit design, outreach, quality improvement, information systems, and human resource development. Clinical standards and implementation guidelines focused on ensuring culturally competence clinical practices and included: discharge planning, treatment services, and communication styles. For each standard, the report included a list of recommended performance indicators and outcomes.

Cross, T.L., Bazron, B.J., Dennis, K.W., Isaacs, M.R. (1999). *Toward a culturally competent system of care, volumes 1 and 2***.** National Institute of Mental Health, Child and Adolescent Service System Program (CASSP) Technical Assistance Center, Georgetown University Child Development Center. Washington, DC.

This monograph outlines a philosophical framework for developing and implementing a service delivery system that provides services in a culturally appropriate way in order to meet the needs of culturally and racially diverse groups. The authors developed a comprehensive cultural competence model that can be used to assist health care professionals to work effectively in cross-cultural situations. The monograph sets forth a six point cultural competence continuum and, outlines the five essential elements that contribute to a system's or agency's ability to become more culturally competent, and identifies a set of underlying values that must be present

in a culturally competent system of care. In addition, the authors provide some practical ideas for improving service delivery at the policymaking, administrative, practitioner, and consumer level.

Goode, T.D. (1989. Revised 1993, 1996, 1999 and 2000) *Promoting cultural and linguistic competency. self-assessment checklist for personnel providing services and support to children with special health needs and their families***.** Georgetown University Child Development Center- National Center for Cultural Competence (NCCC). Washington, DC.

This publication includes self-assessment tools developed by Georgetown University Child Development Center's National Center for Cultural Competence to be used by personnel providing primary health care services. Self-assessment tools were developed for a variety of topic areas, including "values and attitudes", "communication styles", and the "physical environment." Personnel are provided with a checklist that assesses how well they are demonstrating or engaging in practices that promote culturally diverse and competent services.

Leininger, M. (1993). Towards conceptualization of transcultural health care systems: concepts and a model. *Journal of Transcultural Nursing, 4*(2), 32-40.

The Sunrise Model is a comprehensive guide for nurses to use in conducting a cultural care assessment. The model is based on six domains: (1) culture values and lifeways; (2) religious, philosophical, and spiritual beliefs; (3) economic factors; (4) educational factors' technological factors; (5) kinship and social ties; and (6) political and legal factors. It also describes three modalities that can guide nursing interventions so as to provide culturally appropriate care: (1) cultural care preservation and/or maintenance; (2) cultural care accommodation and/or negotiation; and (3) cultural care re-patterning or restructuring. Not all three modalities may be necessary to achieve cultural competent care.

Office of Minority Health (1999). *Assuring cultural competence in health care: Recommendations for national standards and outcomes-focused research agenda***.** Recommended Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care Services. Prepared for the U.S. Department of Health and Human Services. Washington, DC.

This report responds to the need to develop consensus and standards regarding what constitutes cultural or linguistic competence in health care service delivery. This report outlines a set of 14 standards for use by various stakeholders, including providers, policymakers, accreditation and credentialing agencies, purchasers, patients, advocates, educators and the health care community in general. The expectation is that the standards will provide guidance to providers on how to provide culturally competent care and provide policymakers and consumers with the tools to evaluate and assess whether a provider is delivering culturally competent care. The recommended standards were developed with input from a national advisory committee of policymakers, health care providers, and researchers. The process used in developing the standards included the formulation of research questions and a review of technical and policy literature to identify categories of cultural competence. A content analysis of the literature was conducted which identified two thematic clusters corresponding to (1) linguistic competence (i.e., language access, interpreter and translation services) and (2) cultural competence (i.e., patient, staff and organizational cultural diversity management). An initial list of 21 draft standards was consolidated to 14 standards. The standards relate to a variety of areas, including policies and organizational structures, consumer involvement, training and education of staff,

and the provision of interpretation services. Along with recommended national standards, the report also outlines a research agenda for relating the standards to outcomes.

Tirado, M. (1996). *Tools for monitoring cultural competence in health care***.** Prepared by the Latino Coalition for a Health California. San Francisco, CA.

This report was prepared for the Office of Planning and Evaluation at the Health Resources and Services Administration. The report includes tools to monitor providers' cultural competence. Expert panels comprised of primary care physicians and other health care professionals were convened to assist in the development of these provider cultural competence tools. The Expert Panel focused on developing tools targeted at three chronic conditions: asthma, diabetes, and hypertension. Other input was gathered from individual panel member interviews and focus groups conducted with patients. A provider self-assessment and a patient satisfaction survey were developed and included indicators of cultural competence in managed care and other settings.

Mental Health: Culture, Race and Ethnicity, (1999) Surgeon General's Report

Cultural Competency Advisory Committee of the NC Division of MH/DD/SAS, Raleigh, NC 2006

Ngui, E. (October 2001). NC Office of Minority Health and Health Disparities: Minority Health Brief. Raleigh, North Carolina: NC Department of Health and Human Services, Office of Minority Health and Health Disparities.

National Center for Cultural Competence Georgetown University Child Development Center University Center for Excellence in Developmental Disabilities

New York State Office of Mental Health Fact Sheet,
www.omh.state.ny.us/omhweb/ebp/culturalcompetence.html

Cultural Competency Advisory Committee of the NC Division of MH/DD/SAS, Raleigh, NC 2006

Other Articles:

Accomplishing Cross Cultural Competence in Youth Development Programs

Breakthrough Series Collaborative on Reducing Disproportionality and Disparate Outcomes for Children and Families of Color in the Child Welfare System

Child Welfare Terms, English to Spanish

Kaleidoscope: This information was compiled from interviews with people living in the Guilford County community who have come from another country. It reflects their personal insights into their cultural heritage and traditions. This resource is meant to be used not as "an end all to be all" source of information about particular cultural groups, but rather as a reference guide…an introduction to each group's culture…an overview of cultural practices generally considered to be common to people from a particular geographic location outside this country. The hope is that this resource guide will facilitate a two-way communication between the service provider, teacher or counselor and the consumer of services or student. It is meant to provoke questions, not make assumptions or reflect stereotypes and that it will assist in providing a means for our community to become more culturally competent.

Tips for Working with Health Care Interpreters, By Cynthia E. Roat, MPH

> This is a two-page PDF document written by Cynthia E. Roat, MPH for Medical Directions, Inc. The document is entitled, "Tips for Working with Health Care Interpreters." It lists four interpreting Model situations: Working with Any Interpreter; Working with Untrained Interpreters; Working with Telephonic Interpreters and Working with Interpreters in Mental Health. The document offers a description and the pros and cons associated with each.

Understanding English Language Learners' Needs and the Language Acquisition Process: Two Teacher Educators' Perspectives